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# Medicare Trends and Recommendations:

An Analysis of 2022 Call Data from the Medicare Rights Center's  
National Helpline

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## **About the Medicare Rights Center**

Based in New York, the Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Since 1989, Medicare Rights has helped people with Medicare understand their rights and benefits, navigate the Medicare system, and secure the quality health care they deserve.

## **Acknowledgements**

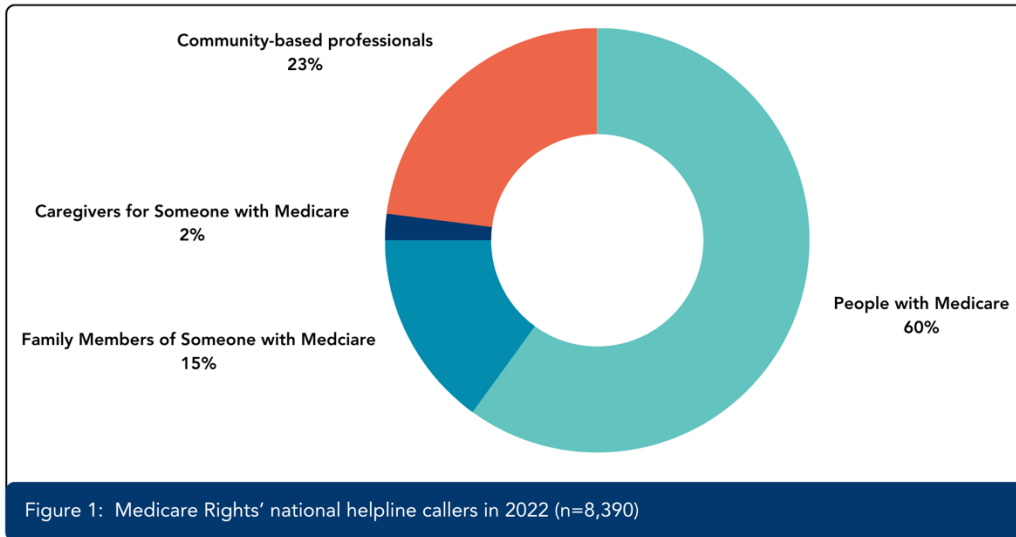
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Disclaimer: All names and identifying details have been changed to protect the privacy of individuals.

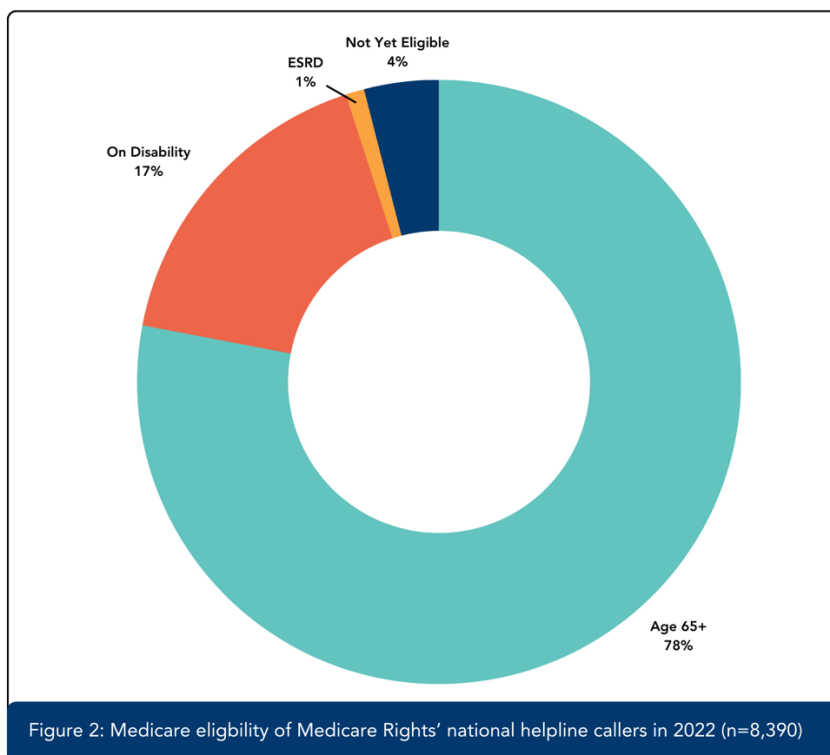
## **Introduction and Summary**

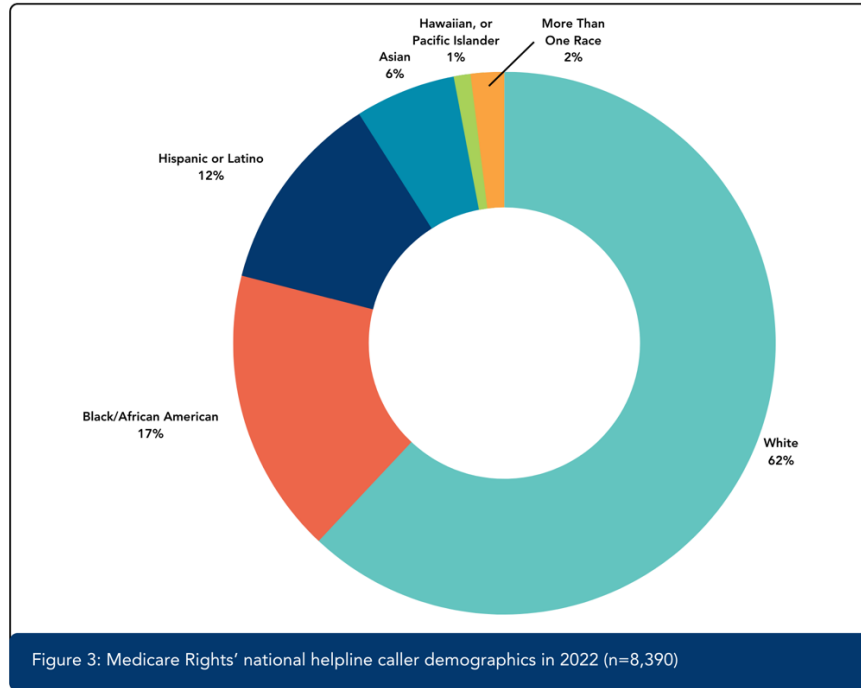
The Medicare Rights Center (Medicare Rights) is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. In 2022, Medicare Rights staff and volunteers addressed more than 27,000 questions through its national helpline and professional email channels. Additionally, Medicare Rights' free and independent online reference tool, Medicare Interactive (MI), provided more than 2.6 million answers for beneficiaries, their caregivers, and professionals. This report features the top helpline trends and highlights the most commonly sought helpline and Medicare Interactive answers, providing a glimpse into the various questions and needs of Medicare beneficiaries, caregivers, and the professionals assisting them in the community in 2022.

People who contact the helpline are diverse and seek guidance, information, and assistance on various complex Medicare issues. Helpline clients include beneficiaries, caregivers, family members, health care providers, and community-based professionals. Of 8,390 people who were counseled on the helpline, 60% were by the Medicare beneficiary themselves, 15% by a family member calling on the beneficiary's behalf, 2% were by caregivers such as friends or power of attorney, and 23% were by community-based professionals.



In 2022, Medicare Rights Center assisted clients in all 50 states, Puerto Rico, the U.S. Virgin Islands, and U.S. citizens living outside the U.S. In terms of eligibility, 78% of beneficiaries were Medicare-eligible due to age (after turning 65), 17% were eligible due to a disability, 1% were eligible due to a diagnosis of End-Stage Renal Disease (ESRD), and 4% were not yet eligible for the program. Of the clients who provided their demographic information, 62% were White, 17% were Black/African American, 12% were Hispanic or Latino, 6% were Asian, and 1% were Native American, Hawaiian, or Pacific Islander, with the remaining 2% identifying as more than one race or ethnicity.





Approximately 44% of Medicare beneficiaries who contacted the helpline reported living on incomes below 150% of the federal poverty level (FPL), which in 2022 was \$20,385 per year for a single individual and \$27,465 per year<sup>1</sup> for a married couple. Dually eligible individuals, meaning those who are eligible for both Medicare and Medicaid, represented a growing percentage of helpline clients: 20% in 2022 compared to 17% over the previous two years.

Medicare Rights' online reference tool, Medicare Interactive, continues to be a popular and valuable resource for people seeking answers to a variety of questions. Medicare Interactive users are composed of Medicare beneficiaries, families and caregivers, and professionals. Figure 4 shows the most frequently visited sections of Medicare Interactive in 2022.

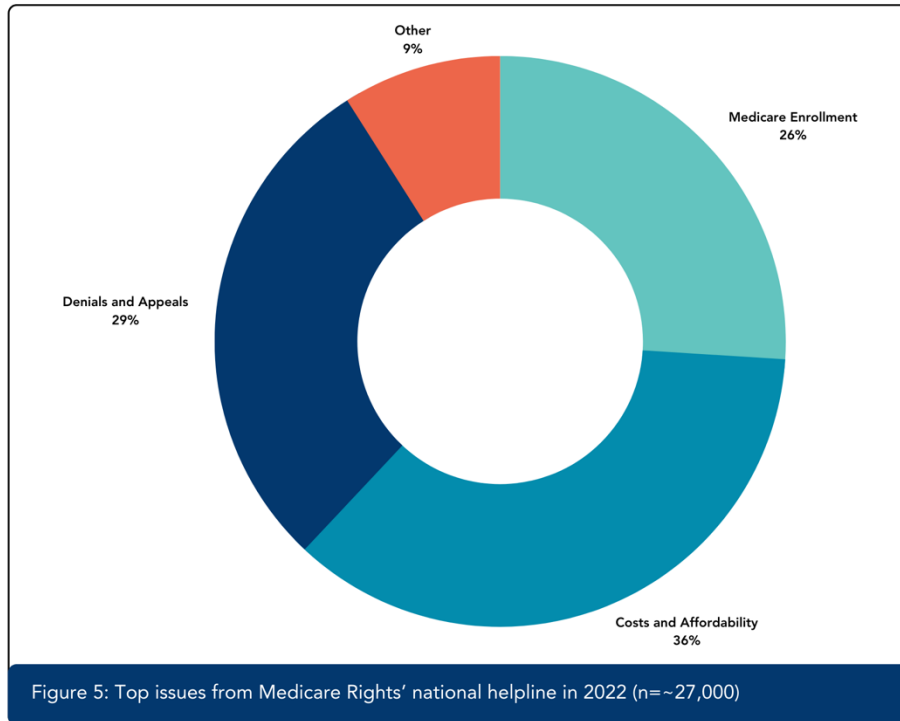
Medicare Interactive Section Title	Page Views	Percent of Total Page Views
Medicare-covered Services	965,468	27%
Medicare Health Coverage Options	649,299	18%
Medicare Basics	626,108	18%
Cost-saving Programs for People with Medicare	435,987	12%
Medicare Prescription Drug Coverage (Part D)	318,597	9%
Coordinating Medicare with Other Types of Insurance	267,834	7%
Medicare Denials and Appeals	142,772	4%
Types of Medicare Advantage Coverage	60,583	2%
Planning for Medicare and Securing Quality Care	50,685	2%
Medicare Fraud and Abuse	9,233	<1%
<b>Total</b>	<b>3,528,930</b>	<b>100%</b>

Figure 4: List of Medicare Interactive Sections, Sorted by Number of Page Views, 2022

### Medicare Trends and Recommendations:

An Analysis of 2022 Call Data from the Medicare Rights Center's National Helpline

In 2022, helpline counselors answered a variety of questions that matched trends from previous years, specifically relating to Medicare enrollment (26% of all calls), costs and affordability (36% of all calls), and denials and appeals (29% of all calls). It is worth noting that Medicare affordability—particularly with regards to the affordability of Medicare’s premiums, copays, and coinsurances—surpassed Medicare enrollment as the top trend in comparison to recent years.



Medicare Rights publishes this report so that stakeholders, including policymakers at the Centers for Medicare & Medicaid Services (CMS) and the Social Security Administration (SSA), lawmakers and elected officials, advocates, and others, can better understand the ongoing and evolving needs of Medicare beneficiaries and strive to improve the Medicare program both within Original Medicare and Medicare Advantage.

## Helpline Trend

### Medicare Affordability

#### Low-Income Benefits & Programs

*Case Story— Jane was a helpline client with a cancer diagnosis. Her illness required that she receive a weekly shot covered under Medicare Part B; however, Jane’s coinsurance of over \$1,500 per shot was completely unaffordable. She called to inquire about a Medicare Savings Program (MSP) and Medicaid to assist with her costs. Her income appeared to be in the range of the Qualified Medicare Beneficiary (QMB) level of the Medicare Savings Program, which pays for Medicare premiums and protects*

*enrollees from being billed for Medicare deductibles, coinsurances, and copayments. With QMB, Jane would not owe the weekly coinsurance for her cancer treatment. MSP enrollment would also automatically enroll Jane in the federal Extra Help program for help paying prescription drug costs.*

In 2022, 36% of calls (9,767 calls) were made by people who needed help paying for Medicare premiums, cost-sharing, and/or Part D prescription drug costs. This represents a 24% increase compared to the previous two years. Additionally, dually eligible beneficiaries accounted for 20% of all helpline clients.

These helpline clients are not alone. Many people with Medicare struggle to afford their coverage: approximately 32% of beneficiaries (18.4 million people) live under 200% of the federal poverty level (FPL).<sup>2</sup> Affordability challenges are particularly acute for enrollees of color, specifically Black and Latino beneficiaries, who are more likely to encounter difficulties in paying for care. In fact, Black and Hispanic beneficiaries are nearly twice as likely as White beneficiaries to face issues in affording and accessing prescription costs.<sup>3</sup> The consequences of unaffordability can be dire, forcing beneficiaries to make impossible choices between paying for rent, food, or needed care.

As noted above, Medicare Rights' consumer helpline has received an increasing number of calls on topics related to affordability, dual eligibility, and cost assistance programs in recent years. Often, beneficiaries are not aware of their eligibility for vital programs, such as MSPs, Extra Help (also called the Low-Income Subsidy, or LIS), and Medicaid. MSPs pay Part B premiums, and in some cases deductibles, copays, and coinsurances; Extra Help—valued by the Social Security Administration as saving beneficiaries an average of \$5,300 a year<sup>4</sup>—lowers a beneficiary's Part D prescription drug costs; and Medicaid provides secondary coverage, paying for Medicare cost-sharing and covering additional services. Each of these programs offers critical financial assistance, which in turn allows beneficiaries to access services that may otherwise be out of reach.

Despite these successes, MSPs and LIS are chronically under-enrolled. An estimated three million people are eligible for LIS but not enrolled. MSP participation rates are similarly low; roughly 2.5 million eligible Medicare enrollees are forgoing this assistance.<sup>5</sup>

### **Prescription Drug Affordability**

*Case Story—Frank, a retired veteran, called the helpline because he had recently lost the Extra Help benefit due to a slight increase in his income by six dollars per month over program limits. He was concerned about the costs of his prescriptions and how he would afford them: many of them had remarkably high copays. A Medicare Rights counselor helped Frank inquire about prescription drug assistance through the Veterans' Administration and learn how to re-apply for the Extra Help benefit in 2023, as income limits were set to increase.*

Whether it's through slight increases or decreases in wages, or the annual cost-of-living increase to Social Security benefits, any change in income can abruptly change a person's eligibility for Medicare cost assistance programs. In circumstances like Frank's, six dollars made the difference between his prescriptions being affordable or prohibitively expensive. Frank's experience speaks to the need for generous income limits so that no one in significant need is at risk of this sort of churning, and for efforts to reduce drug costs and cap out-of-pocket exposure for all beneficiaries.

The Inflation Reduction Act (IRA), elements of which were supported by Medicare Rights and many others, advances these goals. It improves prescription drug affordability in key ways, including for those who are ineligible for low-income benefits but still need help paying prescription drug costs. Beginning in 2023, there is \$0 cost-sharing for vaccines, and insulin copays are limited to \$35 for each one-month supply. In the coming years, the IRA allows for price negotiation between Medicare and drug manufacturers, establishes a hard cap on out-of-pocket Part D costs for all enrollees, and expands eligibility for Extra Help.

### **Policy Recommendation**

#### **Limit Beneficiary Costs & Improve Low-Income Assistance**

- **Include Out-of-Pocket Maximum for Original Medicare:** Unlike most modern health insurance coverage, Original Medicare has no out-of-pocket maximum, exposing beneficiaries to limitless financial risk. Medicare Rights supports establishing a standardized, affordable, out-of-pocket maximum for Medicare Parts A and B in both Original Medicare and Medicare Advantage (MA). While MA Plans currently include an out-of-pocket maximum in their benefit packages, the threshold is too high; \$7,550 for in-network services is far beyond the reach of many Medicare beneficiaries. These containment measures must be coupled with efforts to meaningfully address the drivers of high and rising health care costs.
- **Expand Access to Medicare Low-Income Assistance:** Medicare's low-income assistance programs bolster affordability and outcomes. But, as previously mentioned, far too few who need this help are getting it. Eligible individuals may be unaware of these programs or have difficulty accessing them: helpline clients often report challenges complying with onerous paperwork requirements and application rules. Others may fail to qualify due to the programs' outdated and overly strict eligibility thresholds.

Policymakers should make LIS and MSPs more available and easier to access by eliminating asset tests and raising and standardizing income limits. State-led administrative actions are equally important for ensuring that those who qualify for assistance can obtain it. Medicare Rights appreciates the CMS-identified opportunities

for states to modernize burdensome processes; streamline internal systems; and simplify access, including by auto-enrolling those who qualify for Extra Help into MSPs.

- **Ease Enrollment in Low-Income Assistance Programs:** In addition, states have access to income information that would enable ex parte determination of eligibility and automatic enrollment in most circumstances. Leveraging this data could meaningfully improve program participation. For example, New York State’s recent expansion of MSP income limits has allowed the state to automatically enroll MAGI Medicaid consumers who are becoming Medicare-eligible into the QMB MSP because income limits for MAGI Medicaid and QMB now aligns at 138% of the FPL. Medicare Rights is also advocating with others for New York to use SNAP data to enroll Medicare beneficiaries into MSPs.
- **Improve Outreach Around Low-Income Assistance Programs:** To further address low MSP and LIS uptake, we recommend vigorous outreach, in general and as part of the IRA implementation process. In 2024, the law’s LIS expansion will take effect, extending eligibility for the full subsidy to individuals with incomes up to 150% of the FPL. Individuals now receiving partial LIS benefits will receive enhanced assistance under this expansion, and others will be newly eligible. And those who currently have LIS will remain eligible. We encourage CMS to conduct robust, consistent outreach on this point; such communications could be more impactful if coupled with information about MSP eligibility. This comprehensive approach would best recognize the programs’ shared goals, populations, and enrollment challenges, as well as maximizing opportunities for beneficiary awareness and participation.
- **Increase Funding for SHIPs:** Medicare Rights also supports improved funding for the State Health Insurance Assistance Programs (SHIPs) that help people with Medicare choose the coverage option that best fits their circumstances. With locations in every state, SHIPs are a primary and trusted source of unbiased, one-on-one counseling for people with Medicare. Current funding levels are unable to keep pace with growing demands, which are in part driven by tremendous growth in the Medicare population and an increasingly complex program.

## Helpline Trend

### Medicare Enrollment

*Case Example—Kasey retired in 2020, and despite many conversations with her employer about coverage, made the mistake of declining Medicare Parts A and B and opting into COBRA for 18 months. COBRA provides secondary coverage to Medicare, so Kasey should have enrolled in Medicare Parts A and B at the same time she retired. Kasey realized the mistake at the end of 2021, but she had to wait for the 2022 General Enrollment Period (GEP) to enroll. In 2022, GEP enrollments took effect on July 1, 2022, leaving Kasey without Part B coverage for six months. Kasey was also assessed a late*



*enrollment penalty (LEP) for the year she was without Medicare. Worried about having only Part A, Kasey sought out other insurance, but she was unable to purchase alternative coverage privately or through her state’s Health Insurance Marketplace. This left her vulnerable to prohibitive costs and no coverage during that time.*

In 2022, 26% of helpline calls (7,110 calls) were made by people seeking help enrolling in Medicare, a comparable percentage to 2020-2021. Common questions included how to enroll in Medicare when first eligible at age 65, how to qualify for a Special Enrollment Period (SEP), and when to use the GEP. Often clients were confused about enrollment timelines, where to find clear information, and the consequences of delaying enrollment.

The BENES Act, championed by Medicare Rights, updated Medicare enrollment rules for the first time in over 50 years, ending lengthy waits for coverage and expanding critical enrollment flexibilities.<sup>1</sup> Under these changes, beginning in 2023 people like Kasey who sign up for Medicare during the GEP will now have coverage the month after they enroll.

Even with these modernizations, enrolling in Medicare for the first time remains a daunting task for many reasons. First, the age of Medicare eligibility is untethered from the age when someone qualifies to collect Social Security retirement benefits. Whereas someone can qualify for Medicare at age 65, the full retirement age is 66, and many individuals delay retirement further to age 70 to collect the maximum benefit. This leads to confusion about when to sign up for Medicare. A second factor complicating Medicare enrollment is that many Medicare-eligible individuals continue to work past age 65 and may or may not have coverage through their employer. This leads to questions about whether they can keep the insurance they have from current work, whether they can use a spouse’s job-based insurance, and—as described in the above case example—when and whether they should enroll in Medicare upon retirement.

Many Medicare beneficiaries make mistakes due to a lack of information or understanding of enrollment rules. Failure to enroll on time can have lifelong consequences such as late enrollment penalties and/or gaps in coverage.

## **Policy Recommendation**

### **Modernize Enrollment**

While most people new to Medicare are still automatically enrolled because they are receiving Social Security benefits, a growing number are not. In 2016, only 60% of Medicare-eligible 65-year-olds were taking Social Security, compared to 92% in 2002.<sup>6</sup> This growing cohort must make an active enrollment choice, taking into consideration specific timelines, complex Medicare rules, and existing coverage.

Far too many people make mistakes when trying to navigate this confusing system. The consequences of missteps are significant and may include lifetime financial penalties, higher out-of-pocket health care costs, and gaps in coverage. In 2021 alone, nearly 800,000 people were paying a Part B LEP, the average cost of which increased monthly premiums by nearly 30%.<sup>7</sup>

As recommended by independent experts, notice from the federal government to individuals approaching Medicare eligibility about basic enrollment rules could help prevent these errors.<sup>8</sup> But no such notice exists today. We encourage CMS and SSA to correct this without delay, in fulfillment of obligations to facilitate Part B enrollments, and as outlined in recent legislation, the BENES 2.0 Act.<sup>9</sup>

Medicare Rights strongly supports better remedies to enrollment errors and mistaken delays for those who need it, including through increased use of equitable relief, and maximum flexibility in deploying the BENES Act's exceptional circumstances special enrollment periods (SEPs).<sup>10</sup>

We specifically ask CMS to revisit the definition of "under the authority of a penal authority" as it applies to the Part B SEP for Formerly Incarcerated Individuals. As structured, it is not available to people who are released from physical custody but remain under supervision. This carve-out assumes medical expenses for these individuals are being paid by penal authorities. But in practice, once people are released from physical custody, they rarely have health coverage. Medicaid and the marketplaces reflect this reality in their SEPs, as do the SEPs for Part D and MA, which are triggered by release from physical custody.<sup>11</sup> We support aligning the Part B SEP accordingly.

We also urge policymakers to review the efficacy of the Part B LEP structure. Though intended to encourage individuals to enroll in Medicare when first eligible, complex enrollment rules mean many are likely paying the LEP because of an honest error, not a deliberate deception.<sup>5</sup> Additional study would help determine "whether the late-enrollment penalties are having the desired effects" as well as guide reforms.<sup>6</sup>

## **Policy Recommendation**

### **Improve Consumer Tools and Communications**

Beneficiaries need accurate and easily understood information, and often, individualized assistance. We support ongoing updates to decision-making tools and other resources, including Medicare Plan Finder. Although Plan Finder has information about specific plans, it is limited in its cost and coverage comparisons and can be confusing to use. We recommend better integrating plan network data, individual claims history, and more realistic predictive estimated costs. We also urge CMS to require accurate provider directories, so beneficiaries can make informed coverage decisions and obtain post-enrollment care in a timely manner.

Such network accuracy would also help ensure that plan and official Medicare communications are correct and actionable.

## Policy Recommendation

### Support Informed Decision-Making

Medicare Rights also encourages CMS to explain the differences between Original Medicare and MA in a way that reflects beneficiaries' primary considerations. For example, one of the most significant decision points for many is access to the provider of their choosing. Most MA Plans have ever-shifting networks that may exclude an individual's chosen provider, but this may not be well or widely understood. Even when it is, discovering which providers are in network can be difficult<sup>12</sup> and networks can change at any time,<sup>13</sup> leaving MA enrollees at risk of losing—or never even having—access to their preferred provider. Few resources make this plain.

Dually eligible individuals also may not easily be able to discern the level of Medicare-Medicaid integration a given plan may offer. Such opacity may deprive them of an important criterion for choosing a plan. We urge comprehensive materials and assistance to support these decisions.

Another often overlooked or under-explained trade-off is access to Medigaps. Each year, Medicare's annual enrollment periods allow beneficiaries to change from one MA plan to another, or to switch coverage pathways. But changing from Original Medicare to MA, or vice versa, has profound consequences for affordable Medigap access. Most states lack Medigap enrollment flexibilities and protections that mirror those available through Medicare Advantage, so residents can only sign up during very limited times.<sup>14</sup> Beneficiaries may not know this or the implications of forgoing their Medigap open enrollment period or later cancelling their policy.

Congress and states should address the root of this problem by expanding Medigap access. This includes extending the same federal Medigap protections to beneficiaries under 65 as those given to beneficiaries over 65 and providing for open enrollment, guaranteed issue, and community rating of Medigap for all people with Medicare. In the meantime, CMS—as well as plans, brokers, and other agents—must better and more fully communicate the Medigap-related and other implications of leaving or declining Original Medicare.

## Helpline Trend

### Access to Care

*Case Example—Mary is a dually eligible Medicare beneficiary who enrolled in an MA Plan. Prior to enrollment, she did research on the plan's network, and the plan confirmed that she could see a specific nurse practitioner as her primary care provider.*

*After a visit to the provider, Mary was notified that the visit was denied: she needed to seek prior approval because the provider was out-of-network.*

Many clients like Mary contact the national helpline with questions about how to access care. In 2022 nearly 30% of all helpline calls (7,874 calls) were made by MA enrollees experiencing care access issues, including uncertainty about covered services, billing problems, and coverage denials. Enrollment in MA Plans has been steadily growing, with around 48% of beneficiaries enrolled in a Medicare Advantage Plan and 52% enrolled in Original Medicare in 2022.<sup>15</sup> Despite MA Plans' growing popularity, poor access to care resulting from denials, misleading marketing about plan benefits, network inadequacy, and billing issues remain perpetual issues on Medicare Rights' helpline. A disproportionate 65% of all inquiries about denials of care came from beneficiaries enrolled in Medicare Advantage products.

When selecting an MA Plan, clients like Mary often have to rely on a series of resources—navigating multiple plan websites, working with brokers, speaking with SHIP counselors, or speaking directly with plan representatives—all to simply verify the services and providers that will be covered. Often, clients report not being able to find complete or accurate information regarding provider networks or covered services. Furthermore, provider networks are not available in a centralized location, such as the Medicare Plan Finder tool, making it difficult to compare one MA Plan to another. As in Mary's case, although she confirmed the provider network prior to even enrolling in the plan, she still faced coverage denials after the services had been rendered.

Often the only recourse to denials of coverage is the appeals process, which can be daunting and difficult to navigate. A recent KFF analysis showed that only 11% of prior authorization denials were appealed in 2021. Of those, more than 80% were later overturned, either completely or in part.<sup>16</sup> A 2018 Health and Human Services Office of the Inspector General (OIG) investigation raised similar concerns, finding that while only 1% of prior authorization denials were appealed, 75% were overturned at the first level of review.<sup>17</sup> These reports, and Medicare Rights' own experiences with helpline clients, suggest improper denials are far too common and beneficiary appeals far too rare.

In Mary's case, despite her good-faith efforts to ensure prior coverage for something as straightforward as primary care, she was still denied the service and had to go through the appeal process to get her plan to pay for services. Although many beneficiaries do win their appeals, appealing can be a time-consuming process and success is not guaranteed.

## **Policy Recommendation**

### **Curb Inappropriate Denials**

Medicare Rights appreciates recent CMS efforts to improve MA prior authorization processes. New rules clarify that MA may not deny coverage for services covered by Original Medicare. Rules also increase publicly available information about prior authorization procedures and

rationales.<sup>18</sup> Separately proposed changes would make more details about prior authorization available to enrollees and providers, potentially helping others avoid the issues Mary experienced.<sup>19</sup> While transparency is no panacea, these policies could help aid enrollee choice and increase access to care, as well as inform future policymaking and research.

Better oversight and enforcement are needed to deter and prevent harmful denials, and MA Plans that inappropriately deny care must not be permitted to benefit.<sup>20</sup> Even simple mistakes should spur corrective actions from CMS to ensure that plans take more care in their process design and decision-making.

We ask CMS to monitor MA coverage and care decisions for high denial and overturn rates, low appeal rates, or inappropriate denials for specific services. Emergent trends should trigger more comprehensive reviews to determine the underlying cause of the error and to obligate the plan to resolve it. Plans that regularly engage in such practices should lose the ability to enroll new members or, if the violations are severe, to contract with CMS at all, until corrections are made and publicly documented. Offending plans should remain subject to higher levels of review going forward, and all captured data should be made publicly available.

## **Policy Recommendation**

### **Streamline Appeals**

We continue to urge CMS to simplify the appeals system, including by improving plan communications with enrollees. Under current rules, when plans issue a denial, they are required to notify the affected enrollee in a timely manner. Without this notice, beneficiaries may not understand their rights, how to appeal, or even that they have been denied coverage. Despite the importance of this obligation, many plans fail to comply.<sup>21</sup>

CMS must do more to make sure that plan notices are correct, promptly delivered, available in languages other than English, and accessible to people with varying levels of health literacy. We also support invalidating and immediately escalating coverage denials that were not accompanied by proper notice.

In addition to notice requirements, appeals should be streamlined by reducing the number of steps enrollees must take. In Part D, for example, a beneficiary who gets a denial of coverage at the pharmacy counter must independently request a formal and separate coverage determination request rather than being able to appeal the point-of-sale denial directly. This extra step creates an unnecessary barrier to care. In all appeals, the first level of review should be handled by an independent entity, rather than the plan. This would simplify the system, help ensure that beneficiaries have more timely access to care and encourage plans to make accurate initial coverage determinations.

## Helpline Trend

### Supplemental Benefits

*Case Example—Edward was enrolled in an MA Plan, and he was interested in their supplemental benefits such as dental. Edward knew he needed routine dental care along with additional services like fillings in the future. When speaking to a plan representative, they confirmed that the plan covered comprehensive dental. Edward received his fillings, but he then received a notice from the plan informing him that fillings were not a covered service.*

Frequently, Medicare beneficiaries contact the helpline with questions about supplemental benefits, which are items or services covered by an MA Plan that are not covered by Original Medicare. Common supplemental benefits include dental, vision, hearing, and transportation. In recent years, plans have been allowed to offer a wider array of “extra” benefits, including gym memberships and other non-medical services. For plans, this coverage can be a powerful marketing tool. In 2022, supplemental benefits were the most common reason enrollees cited for choosing an MA Plan over Original Medicare,<sup>22</sup> despite an alarming lack of data on their utilization, quality, and value.<sup>23</sup>

In 2022, 71% of helpline calls about Medicare Advantage supplemental benefits were related to dental care. Often, calls were general inquiries as to whether dental services are covered under Medicare. Yet many were regarding an MA Plan’s denial, including instances where providers were out of network or the dental services in question were not covered.

Clients express frustration about finding information on or accessing supplemental benefits because they vary from plan to plan, can change every year, and have different eligibility requirements. The lack of transparency and oversight around these offerings regularly creates confusion. For instance, consumers may believe that all MA Plans offer all supplemental benefits to all enrollees, or that a given benefit is more generous than it later proves to be.

## Policy Recommendation

### Improve Data and Transparency

When it comes to supplemental benefits, there is far too much we do not know about their marketing, access, uptake, cost, and denials. Enrollees and the public need better information about these benefits and their administration.

CMS must closely examine and publicly report on the value and usage of supplemental benefits, including from an equity perspective. For example, we urge CMS to analyze data on physical activity-related supplemental benefits, which have been shown to attract younger and healthier enrollees who require fewer health services.<sup>24</sup> Such offerings, coupled with barriers like prior authorization that disproportionately affect sicker enrollees, may result in MA Plans skewing their population toward healthier, less costly enrollees. According to KFF, “In general,

Medicare Advantage plans typically use prior authorization for relatively high-cost services used by enrollees with significant medical needs, such as inpatient care and drugs covered under Medicare Part B.<sup>25</sup>

Moreover, supplemental benefits should have sufficient data transparency to serve as a testing ground for services that may provide substantial health benefits and could be incorporated into Original Medicare.

### **Policy Recommendation**

#### **Strengthen Guardrails/Beneficiary Protections**

Medicare Rights also asks CMS to advance rulemaking about plan marketing of supplemental benefits. Clear guidelines and increased transparency would allow CMS to better oversee marketing materials, and for beneficiaries and advocates to raise concerns when promised services are not being delivered. It is essential to continually verify that plans are not merely using supplemental benefits as a selling point, but are providing them adequately, equitably, and promptly.

We also support CMS establishing network adequacy requirements and clear appeals processes for this coverage, as well as including better information about supplemental benefits on Medicare Plan Finder and other resources on which beneficiaries rely to make informed coverage decisions.

### **Policy Recommendation**

#### **Fill Gaps in Coverage**

While MA Plans can offer some vision, dental, and hearing coverage, it is typically limited, and not available to beneficiaries with Original Medicare. Medicare Rights supports adding comprehensive coverage for these services to Medicare Part B.<sup>26</sup> Doing so would best ensure consistent, widespread availability of these health-essential services.

### **Conclusion**

Data from Medicare Rights Center's 2022 national helpline shed light on the many obstacles Medicare beneficiaries and their caregivers regularly face when trying to access and afford needed medical care. The main trends—affordability, enrollment, and access to care—remained steady from prior years, demonstrating the work that still needs to be done to strengthen and improve the Medicare program for all beneficiaries. Medicare Rights Center looks forward to continuing to work with CMS, SSA, fellow advocates, and beneficiaries to strengthen and protect the Medicare program for this and future generations.



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